ALAMEDA COUNTY CRISIS RESIDENTIAL TREATMENT REFERRAL FORM

☐ **Amber House, 516 – 31st Street, Oakland, CA 94609. Phone: (510) 379-4394, Fax: (510) 423-0833**
Amberreferrals@bayareacs.org

☐ **Jay Mahler Recovery Center, 15430 Foothill Blvd, San Leandro, CA 94578. Phone: (510) 246-1589, Fax: (510) 357-3614**
JMCreferrals@telecarecorp.com

☐ **Woodroe Place, 22505 Woodroe Avenue, Hayward, CA 94541. Phone: (510) 537-1688, Fax: (510) 265-8815**
Woodroereferrals@bayareacs.org

Referral Date:	**Referring Agency:**
Referring Clinician Name:	**Contact Number:**

CLIENT INFORMATION

Client Name:	**DOB:**	**Age:**
Gender:	**SSN (If no SSN, include PSP):**	
Primary Language:	**Client Phone # (if applicable):**	
Income Source/Amount:	**Insurance:**	
Conservator:	**Alameda County Resident:** ☐ **Yes** ☐ **No**	
Legal Status (PC290, 1370.01, etc):		
Current Living Situation:	**Is client able to return? (If no, state reason)**	
Outpatient Services Team:	**Outpatient Clinician:**	
Contact Number and Email:		

CLINICAL INFORMATION

Diagnoses (please include primary and secondary):

Substance Use (please include substances used and any withdrawal concerns, signs or symptoms):

Risk Factors: ☐ **Danger to Self** ☐ **Danger to Others** ☐ **AWOL/AMA Risk** ☐ **Other:**
Please elaborate on any checked boxes:

Reason for referral (please include description of precipitating events as well as current symptoms):

Please list all current medications (include over the counter medications):

TB SCREENING/CLEARANCE

Has client ever had TB?	☐ Yes	☐ No	**PPD test in last 12 mos?**	☐ Yes	☐ No
Has client ever had BCG?	☐ Yes	☐ No	**Chest X-Ray in last 12 mos?**	☐ Yes	☐ No
Past exposure to TB?	☐ Yes	☐ No	**If yes, when and where:**		

SIGNS & SYMPTOMS: Check the appropriate box for any symptom that the client is currently experiencing:

Fatigue; Malaise	☐ Yes	☐ No	**Unexplained weight loss**	☐ Yes	☐ No
Anorexia (loss of appetite)	☐ Yes	☐ No	**Fever (usually at night)**	☐ Yes	☐ No
Night sweats (drenching)	☐ Yes	☐ No	**Cough**	☐ Yes	☐ No
Hemoptysis (spitting blood)	☐ Yes	☐ No	**Pain in chest**	☐ Yes	☐ No

If marked yes to any above, please explain:

PPD Administered Date:	**PPD Read Date:** ☐ Positive ☐ Negative

Other infectious/contagious illnesses (Include signs of lice, bed bugs, scabies, etc.): ☐ Yes ☐ No **If yes, describe:**

PHYSICAL HEALTH STATUS

Medical Diagnoses (Please include treatment protocol and necessary follow-up):

Ambulatory Status: ☐ Ambulatory ☐ Ambulatory with assistive device* ☐ Non-ambulatory ☐ Bedridden

***If with assistive device, please indicate:**	**Does client have w/them?**	☐ Yes ☐ No	☐ N/A
	Can client transfer on own?	☐ Yes ☐ No	☐ N/A

Physical Impairments			**Capacity for Self-Care**		
Auditory impairment	☐ Yes	☐ No	**Currently taking meds**	☐ Yes	☐ No
Visual impairment	☐ Yes	☐ No	**Can administer own meds**	☐ Yes	☐ No
Bowel/Bladder impairment	☐ Yes	☐ No	**If on insulin, able to measure blood sugar and self administer insulin**	☐ Yes	☐ No ☐ N/A
If yes, please describe:					
Able to care for any wounds	☐ Yes	☐ No	**Bathes/Dresses/Feeds Self**	☐ Yes	☐ No
Other impairments:			**Able to leave unassisted**	☐ Yes	☐ No

Mental Status			**Special Diet:**
Confused	☐ Yes	☐ No	
Able to follow instructions	☐ Yes	☐ No	**Allergies:**
Able to communicate	☐ Yes	☐ No	

Print MD Name:	**Facility Name:**
MD Signature:	**Date:**